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Division of Administration Office of Group Benefits

Public Hearing – Substantive Changes to Proposed Rule Employee Benefits

(LAC 32:I.319, 323, 1109; LAC 32:III.105, 107, 109; and LAC 32:V.203, 205, 207, 305, 307, 405, 505, 507)

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, the Office of Group Benefits published a Notice of Intent in the May 20, 2017, edition of the Louisiana Register to implement several changes to the Office of Group Benefits rules. Office of Group Benefits received written comments on the proposed rulemaking and facilitated a public hearing on June 28, 2017, to receive comments and testimony on the proposed Rule. After a thorough review and careful consideration of the comments and testimony received on the Notice of Intent, the Office of Group Benefits has decided not to pursue at this time the provisions of the original proposed Rule regarding the implementation of tobacco and spousal surcharges (proposed LAC 32:1.510) or the revisions to LAC 32:I.315. Office of Group Benefits will proceed with the remainder of the proposed rulemaking with no changes, as set forth below. These actions will enhance member clarification and provide for the administration, operation, and management of health care benefits effectively for the program and member. The fiscal and economic impacts of the remaining portions of the Notice of Intent have been sent to the Legislative Fiscal Office for evaluation.

Title 32 EMPLOYEE BENEFITS Part I. General Provisions

Chapter 3. Uniform Provisions—Participation in the Office of Group Benefits

§319. Continued Coverage

A. - C.4. ...

D. Over-Age Dependents. If a dependent child who is the natural or adopted child of the enrollee is incapable of self-sustaining employment by reason of mental or physical incapacity and became incapable prior to attainment of age 26, the coverage for that dependent child may be continued for the duration of incapacity.

D.1. - E.3.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:341 (February 2015), effective March 1, 2015, amended LR 43:

§323. Employer Responsibility

A. ...

B. A participating employer shall immediately inform OGB when a retiree with OGB coverage returns to benefit-eligible employment. The enrollee shall be placed in the reemployed retiree category for premium calculation. The reemployed retiree premium classification applies to retirees with and without Medicare. The premium rates applicable to the re-employed retiree premium classification shall be identical to the premium rates applicable to the classification for retirees without Medicare. If the re-employed retiree suspends retirement benefits and returns to benefit-eligible employment with the agency from which the re-employed

retiree originally retired, the employee portion of the premium shall be withheld by payroll deduction and the employing agency shall remain responsible for the employer portion of the premium. If the re-employed retiree suspends retirement benefits and returns to benefit-eligible employment with an OGB participating agency other than the agency from which the re-employed retiree originally retired, the employee portion of the premium shall be withheld by payroll deduction, and the employing agency shall be responsible for the employer portion of the premium throughout the duration of employment. If the re-employed retiree returns to benefit-eligible employment, yet does not suspend retirement benefits as allowed by law, the employee portion of the premium shall be withheld by payroll deduction, and the employing OGB participating agency shall be responsible for the employer portion of the premium throughout the duration of employment. When the reemployed retiree separates from employment with the OGB participating employer, the employer shall notify OGB of such separation within 30 days. After the re-employed retiree again separates from employment with an OGB participating employer, the agency from which the re-employed retiree originally retired shall again be responsible for the employer portion of the premium.

C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:345 (February 2015), effective March 1, 2015, amended LR 41:2351 (November 2015), effective January 1, 2016, amended LR 43:

Chapter 11. Contributions §1109. Retirees with Medicare Parts A and B

A. Employees who retire on or after July 1, 1997, and who are not rehired retirees in a benefit-eligible position, shall receive a reduced premium rate when enrolled in Medicare Parts A and B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 24:496 (March 1998), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:

Part III. Primary Plan of Benefits Chapter 1. Operation of Primary Plan §105. Out of Pocket Maximums

Out-of-Pocket Maximu (Includes All Eligit Coinsurance Amount	ole Copaymen	ts,
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$3,500	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$2,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$6,000	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$3,000	No Coverage
Individual, Plus Two or More Dep	endents:	
Active Employee/Retirees on or after March 1, 2015	\$8,500	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$4,000	No Coverage

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:

§107. Schedule of Benefits

A. Benefits, Copayments, and Coinsurance

	Copayments a	nd Coinsurance
	Network Providers	Non- Network Providers
Physician Office Visits including surgery performed in an office setting: General Practice Family Practice Internal Medicine OB/GYN Pediatrics	\$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits:	\$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: Physician Podiatrist Optometrist Midwife Audiologist Registered Dietician Sleep Disorder Clinic	\$50 Copayment per Visit	No Coverage
Ambulance Services – Ground (for Emergency Medical Transportation only)	\$50 Copayment	\$50 Copayment
Ambulance Services - Air (for Emergency Medical Transportation only) Non-Emergency requires prior authorization ²	\$250 Copayment	No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	\$100 Copayment	No Coverage
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	No Coverage
Cardiae Rehabilitation (<i>limit of 36</i> visits per Plan Year)	\$25/\$50 Copayment per day depending on Provider Type ² \$50 Copayment - Outpatient Facility ²	No Coverage
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	Office - \$25 Copayment per Visit Outpatient Facility 100% - 0% ^{1,2}	No Coverage
Diabetes Treatment	80% - 20%1	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	\$25 Copayment 100% - 0% ¹	No Coverage
Dialysis	100% - 0%.	No Coverage

	Copayments ar	nd Coinsurance
	Network Providers	Non- Network Providers
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Emergency Room (Facility Charge)		ent; Waived if e same facility
Emergency Medical Services (Non-Facility Charges)	100% - 0%1	100% - 0%1
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames – Limited to a Maximum Benefit of \$501	No Coverage
Flu shots and HIN1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	No Coverage
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older.)	80% - 20%1.3	No Coverage
Hearing Impaired Interpreter Expense	100% - 0%	No Coverage
High-Tech Imaging – Outpatient CT Scans MRA/MRI Nuclear Cardiology PET Scans	\$50 Copayment ²	No Coverage
Home Health Care (limit of 60 Visits per Plan Year)	100% - 0%1.2	No Coverage
Hospice Care (limit of 180 Days per Plan Year)	100% - 0%1.2	No Coverage
Injections Received in a Physician's Office (when no other health service is received)	100% - 0%1	No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	\$100 Copayment per day², maximum of \$300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable	100% - 0%1	No Coverage
Mastectomy Bras – Ortho-Mammary Surgical (limited to three (3) per Plan Year)	80% - 20% ¹ of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Mental Health/Substance Abuse – Inpatient Treatment and Intensive Outpatient Programs	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
	1	
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs) Newborn – Sick, Services excluding	\$25 Copayment per Visit	No Coverage

	Copayments ar	nd Coinsurance
	Network Providers	Non- Network Providers
Newborn – Sick, Facility	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Oral Surgery	100% - 0%1.2	No Coverage
Pregnancy Care – Physician Services	\$90 Copayment per pregnancy	No Coverage
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.)	100% - 0%³	No Coverage
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational (Limited to 50 Visits combined PT/OT per Plan Year, Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders.)	\$25 Copayment per Visit	No Coverage
Skilled Nursing Facility (limit of 90 days per Plan Year)	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Sonograms and Ultrasounds (Outpatient)	\$50 Copayment	No Coverage
Urgent Care Center	\$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	\$25/\$50 Copayment depending on Provider Type	No Coverage
X-ray and Laboratory Services (low-tech imaging)	Hospital Facility 100%-0% ¹ Office or Independent Lab 100%-0%	No Coverage
¹ Subject to Plan Year Deductible, if appl ² Pre-Authorization Required, if applicab primary. ³ Age and/or Time Restrictions Apply		for Medicare

AUTHORITY NOTE: Promulgated in accordance with R.S.

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:

§109. Prescription Drug Benefits

A. Prescription Drug Benefits

42:801(C) and 802(B)(1).

Network Pharmacy	Member pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80

90 day supplies for maintenance	Two and a half times the cost of
drugs from mail order OR at	your applicable copayment
participating 90-day retail	
network pharmacies	
Co-Payment after the Out Of	Pocket Amount of \$1,500 Is Met
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription drug b	penefits-31 day refill
	of eligible expenses
	to a copayment if enrolled in the In- anagement Program.
generic version is available, pays the name drug & the generic drug, plus	name drug for which an approved ne cost difference between the brand- s the co-pay for the brand-name drug; o the \$1,500 out of pocket maximum
	unter in the same prescribed strength ler the pharmacy plan.
Benefits are available for Prescri smoking cessation medications (Prescription is required for over-	tion Medications: iption and over-the-counter (OTC) when prescribed by a physician. the-counter medications). Smoking s are covered at 100%.
and Drug Administration or its su Utilization management criteria	and medicines approved by the Food accessor that require a prescription, may apply to specific drugs or drug etermined by PBM.

В. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:352 (February 2015), effective March 1, 2015, amended LR 43:

Part V. Additional Plans and Operations Chapter 2. PPO Plan Structure - Magnolia Open Access Plan

§203. Out of Pocket Maximums

			ible Copaym		
	Active Employee/Retirees on or after March 1, 2015		Retirees March Without	1, 2015	Retirees prior to March 1, 2015 With Medicare
	Network	Non- Network	Network	Non- Network	Network and Non- Network
Individual Only	\$3,500	\$4,700	\$2,300	\$4,300	\$3,300
Individual Plus One (Spouse or Child)	\$6,000	\$8,500	\$3,600	\$7,600	\$5,600
Individual Plus Two	\$8,500	\$12,250	\$4,900	\$10,900	\$7,900
Individual Plus Three	\$8,500	\$12,250	\$5,900	\$13,700	\$9,900
Individual Plus Four	\$8,500	\$12,250	\$6,900	\$13,700	\$11,900
Individual Plus Five	\$8,500	\$12,250	\$7,900	\$13,700	\$13,700
Individual Plus Six	\$8,500	\$12,250	\$8,900	\$13,700	\$13,700

		des All Elig rance Amou			
	Active Employee/Retirees on or after March 1, 2015		Retirees March Without	1, 2015	Retirees prior to March 1, 2015 With Medicare
	Network	Non- Network	Network	Non- Network	Network and Non- Network
Individual Plus Seven	\$8,500	\$12,250	\$9,900	\$13,700	\$13,700
Individual Plus Eight	\$8,500	\$12,250	\$10,900	\$13,700	\$13,700
Individual Plus Nine	\$8,500	\$12,250	\$11,900	\$13,700	\$13,700
Individual Plus Ten	\$8,500	\$12,250	\$12,900	\$13,700	\$13,700
Individual Plus Eleven or More	\$8,500	\$12,250	\$13,700	\$13,700	\$13,700

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:355 (February 2015), effective March 1, 2015, amended LR 43:

§205. Schedule of Benefits

A. Benefits and Coinsurance

		Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date	
	Network Providers	Non-Network Providers	Network and Non-Network Providers	
Physician Office Visits				
including surgery performed				
in an office setting:				
General Practice	90% - 10%1	70% - 30%1	80% - 20%	
Family Practice	30,00 10,0	, , , , ,	00,0 20,0	
Internal Medicine				
OB/GYN				
Pediatrics		×		
Allied Health/Other				
Professional Visits: • Chiropractors				
	İ			
Federally Funded Qualified Rural Health Clinics	90% - 10%1	70% - 30%	80% - 20%	
Nurse Practitioners	9070 - 1070	1070 - 3070	0U70 - ZU70°	
Retail Health Clinics				
Retail Health Chines				
Physician Assistants				
Specialist (Physician) Office Visits including				
surgery performed in an office setting:				
Physician				
 Podiatrist 				
Optometrist	90% - 10%1	70% - 30%1	80% - 20%1	
 Midwife 				
 Audiologist 				
Registered Dietician				
Sleep Disorder Clinic				
Ambulance Services - Ground	90% - 10%1	70% - 30%1	80% - 20%	
(for Emergency Medical Transportation only)				
Ambulance Services - Air	90% - 10%1	70% - 30%1	80% - 20%1	
(for Emergency Medical Transportation only) Non-emergency requires prior authorization ²	90% - 10%	10% - 30%	80% - 20%	
Ambulatory Surgical Center and Outpatient				
Surgical Facility	90% - 10%1	70% - 30%1	80% - 20%1	
S			Network Providers	
Birth Control Devices - Insertion and	1000/ 00/	700/ 200/1	100% - 0%	
Removal (as listed in the Preventive and	100% - 0%	70% - 30%1	Non-Network Providers	
Wellness Care Article in the Benefit Plan)			80% - 20%1	
Cardiac Rehabilitation	90% - 10%1.2	70% - 30%1.2	80% - 20%12	
limit of 36 visits per Plan Year)	li t			
Chemotherapy/Radiation Therapy (Authorization	90% - 10%1.2	70% - 30%1.2	80% - 20% 1.2	
not required when performed in Physician's office)				
Diabetes Treatment	90% - 10%1	70% - 30%1	80% - 20%	
Diabetic/Nutritional Counseling - Clinics and	90% - 10%1	Not Covered	80% - 20%	
Outpatient Facilities	2070 1070		1 2070	

		Coinsurance	1
	Active Em		Retirees with Medicare
erangia karakanda a mangaza a sa sa sa sa sa	Non-Medicare Retirees (re	Non-Network	(regardless of retire date) Network and
	Network Providers	Providers	Non-Network Providers
Dialysis	90% - 10%1	70% - 30%¹	80% - 20%1
Durable Medical Equipment (DME), Prosthetic	90% - 10%1.2	70% - 30%1.2	80% - 20%1.2
Appliances and Orthotic Devices Emergency Room (Facility Charge)	\$150 Copay	ment ¹ ; Waived if admitted to th	ne same facility
Emergency Medical Services	90% - 10%	90% - 10%1	80% - 20%
(Non-Facility Charges)	90% - 10%.	9070 - 1070	8076 - 2076
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Fra	ames - Limited to a Maximum	Benefit of \$50 ¹
Flu shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	100% - 0%	100% - 0%
Hearing Aids (Hearing Aids are not covered for	90% - 10%1.3	70% - 30% ^{1,3}	80% - 20%1.3
individuals age eighteen (18) and older) Hearing Impaired Interpreter Expense	100% - 0%	100% - 0%	100% - 0%
High-Tech Imaging – Outpatient	10070 070	.0070 070	10070 070
 CT Scans MRA/MRI Nuclear Cardiology PET Scans 	90% - 10%1.2	70% - 30% ^{1,2}	80% - 20%1.2
Home Health Care (limit of 60 Visits per Plan Year)	90% - 10%1.2	70% - 30%1.2	Not Covered
Hospice Care (limit of 180 Days per Plan Year)	80% - 20%1.2	70% - 30%1.2	Not Covered
Injections Received in a Physician's Office (when no other health service is received)	90% -10%1	70% - 30%	80% - 20%
Hospital Service Included Per Day Copayment Day Maximum Coinsurance	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1,2}	\$0 Not Applicable 80% - 20% ^{1,2}
Inpatient and Outpatient Professional Services	90% - 10%1	70% - 30%1	80% - 20%1
Mastectomy Bras - Ortho-Mammary Surgical (limit of three (3) per Plan Year)	90% - 10%1	70% - 30%1	80% - 20%1
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs Per Day Copayment Day Maximum Coinsurance	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1.2}	\$0 Not Applicable 80% - 20% ^{1,2}
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	90% - 10%	70% - 30%	80% - 20%1
Newborn - Sick, Services Excluding Facility	90% - 10%1	70% - 30%	80% - 20%1
Newborn - Sick, Facility Per Day Copayment Day Maximum Coinsurance	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1.2}	\$0 Not Applicable 80% - 20% ^{1.2}
Oral Surgery for Impacted Teeth	90% - 10%1.2	70% - 30% ^{1,2}	80% - 20% ^{1.2}
Pregnancy Care - Physician Services	90% - 10%1	70% - 30%1	80% - 20% 1
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness Care Article in the Benefit Plan.)	100% - 0%³	70% - 30% ^{1,3}	Network 100% - 0 ³ Non-Network 80% - 20% ^{1.3}
Rehabilitation Services - Outpatient: • Speech • Physical/Occupational (Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders)	90% - 10%1	70% - 30% ¹	80% - 20%1
Skilled Nursing Facility (limit 90 days per Plan Year)	90% - 10%1.2	70% - 30% 1.2	80% - 20%1.2
Sonograms and Ultrasounds (Outpatient)	90% - 10%1	70% - 30%1	80% - 20%1
Urgent Care Center	90% - 10%	70% - 30%1	80% - 20%1

		Coinsurance	
		Active Employees/ Non-Medicare Retirees (regardless of retire date)	
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Vision Care (Non-Routine) Exam	90% - 10%1	70% - 30%	80% - 20%1
X-ray and Laboratory Services (low-tech imaging)	90% - 10%1	70% - 30%1	80% - 20%
Subject to Plan Year Deductible, if applicable	E. D. C. M. F.		
² Pre-Authorization Required, if applicable. Not a ³ Age and/or Time Restrictions Apply	pplicable for Medicare primary.		

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:356 (February 2015), effective March 1, 2015, amended LR 43:

§207. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member Pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance	Two and a half times the cost of your
drugs from mail order OR at	applicable copayment
participating 90-day retail	
network pharmacies	
	Of Pocket Amount of \$1,500 Is Met
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription dru	g benefits-31 day refill
Plan pays balan	ce of eligible expenses
version is available, pays the cost & the generic drug, plus the co-	me drug for which an approved generic difference between the brand-name drug pay for the brand-name drug; the cost the \$1,500 out of pocket maximum
	unter in the same prescribed strength are ler the pharmacy plan.
Benefits are available for Pres smoking cessation medicatio (Prescription is required for over	sation Medications: cription and over-the-counter (OTC) ns when prescribed by a physician. er-the-counter medications). Smoking ons are covered at 100%.
and Drug Administration or its Utilization management criteria	gs and medicines approved by the Food successor that require a prescription. a may apply to specific drugs or drug determined by PBM.

В. .

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:358 (February 2015), effective March 1, 2015, amended LR 43:

Chapter 3. Narrow Network HMO Plan Structure—Magnolia Local Plan (in certain geographical areas)

§305. Schedule of Benefits

A. Benefits, Copayments, and Coinsurance

	Copayments and Coinsurance	
confluencial Marchine Inches	Network	Non-Network
Physician Office Visits including	Providers	Providers
Physician Office Visits including surgery performed in an office setting:	\$25	
 General Practice Family Practice Internal Medicine OB/GYN Pediatrics 	Copayment per Visit	No Coverage
Allied Health/Other Professional		
Visits:		
 Chiropractors Federally Funded Qualified Rural Health Clinics Nurse Practitioners 	\$25 Copayment per Visit	No Coverage
Retail Health Clinics		
Physician Assistants Specialist Office Visits including		
surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	\$50 Copayment per Visit	No Coverage
Ambulance Services - Ground (for Emergency Medical Transportation only)	\$50 Copayment	\$50 Copayment
Ambulance Services - Air (for Emergency Medical Transportation only) Non-emergency requires prior authorization ²	\$250 Copayment	No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	\$100 Copayment	No Coverage
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan.)	100% - 0%	No Coverage
Cardiac Rehabilitation (<i>limit of</i> 36visits per Plan Year)	\$25/\$50 Copayment per day depending on Provider Type ² \$50 Copayment- Outpatient Facility ²	No Coverage

		nd Coinsurance
	Network Providers	Non-Network Providers
	Office – \$25	Troviders
Chemotherapy/Radiation Therapy	Copayment	
(Authorization not required when	per Visit	No Coverage
performed in Physician's office)	Outpatient	110 COVERAGE
	Facility 100% - 0% ^{1.2}	
Diabetes Treatment	80% - 20%1	No Coverage
Diabetic/Nutritional Counseling -		
Clinics and Outpatient Facilities	\$25 Copayment	No Coverage
Dialysis	100% - 0%1	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ¹² of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan	No Coverage
	Year \$150 Copayin	lent; Waived if
Emergency Room (Facility Charge)		ne same facility
Emergency Medical Services (Non-Facility Charges)	100% - 0%1	100% - 0%1
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames – Limited to a Maximum Benefit of \$501	No Coverage
Flu shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	No Coverage
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older.)	80% - 20%1.3	No Coverage
Hearing Impaired Interpreter Expense	100% - 0%	No Coverage
High-Tech Imaging - Outpatient CT Scans MRA/MRI Nuclear Cardiology PET Scans	\$50 Copayment ²	No Coverage
Home Health Care (limit of 60 Visits per Plan Year)	100% - 0%1.2	No Coverage
Hospice Care (limit of 180 Days per Plan Year)	100% - 0%1.2	No Coverage
Injections Received in a Physician's Office (when no other health service is received)	100% - 0%¹	No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for which a Copayment is Not Applicable	100% - 0%¹	No Coverage
Mastectomy Bras (limited to three (3) per Plan Year)	80% - 20% of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	\$25 Copayment per Visit	No Coverage

Copayments and Coinsurance	
Network Providers	Non-Network Providers
100% - 0%1	No Coverage
\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
100% - 0%1.2	No Coverage
\$90 Copayment per pregnancy	No Coverage
100% - 0%³	No Coverage
\$25 Copayment per Visit	No Coverage
\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
\$50 Copayment	No Coverage
\$50 Copayment	No Coverage
\$25/\$50 Copayment depending on Provider Type	No Coverage
Hospital Facility 100% - 0% ¹ Office or Independent Lab 100% - 0%	No Coverage
	Network Providers 100% - 0%¹ \$100 Copayment per day², maximum of \$300 per Admission 100% - 0%¹²² \$90 Copayment per pregnancy 100% - 0%³ \$25 Copayment per Visit \$100 Copayment per day², maximum of \$300 per Admission \$50 Copayment \$25/\$50 Copayment \$25/\$50 Copayment depending on Provider Type Hospital Facility 100% - 0%¹ Office or

Age and/or Time Restrictions Apply

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:359 (February 2015), effective March 1, 2015, amended LR 43:

§307. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable copayment
Co-Payment after the Out O	f Pocket Amount of \$1,500 Is Met
Tier 1- Generic	\$0
Tier 2- Preferred	\$20

Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription	drug benefits-31 day refill
Plan pays ba	lance of eligible expenses
	bject to a copayment if enrolled in the Insee Management Program.
version is available, pays the co & the generic drug, plus the	-name drug for which an approved generic ost difference between the brand-name drug co-pay for the brand-name drug; the cost to the \$1,500 out of pocket maximum
	-counter in the same prescribed strength are under the pharmacy plan.
Benefits are available for P smoking cessation medica (Prescription is required for	Cessation Medications: Prescription and over-the-counter (OTC) ations when prescribed by a physician. over-the-counter medications). Smoking cations are covered at 100%.
and Drug Administration or Utilization management crit	drugs and medicines approved by the Food its successor that require a prescription. teria may apply to specific drugs or drug be determined by PBM.

B. ..

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:360 (February 2015), effective March 1, 2015, amended LR 43:

Chapter 4. PPO/Consumer-Driven Health Plan Structure—Pelican HSA 775 Plan

§405. Schedule of Benefits

A. Benefits and Coinsurance

the desirable of the section of the	Coinsurance	
	Network Providers	Non- Network Providers
Physician's Office Visits including		
surgery performed in an office setting:		
General Practice		
Family Practice	80% - 20%1	60% - 40%1
 Internal Medicine 		
• OB/GYN		1
 Pediatrics 		
Allied Health/Other Office Visits:		
 Chiropractors 		
 Federally Funded Qualified Rural 		
Health Clinics	80% - 20%1	60% - 40%1
 Retail Health Clinics 		
Nurse Practitioners		
Physician's Assistants		
Specialist Office Visits including surgery		
performed in an office setting:		
Physician		
 Podiatrist 		
Optometrist	80% - 20%1	60% - 40%1
 Midwife 		
 Audiologist 		
Registered Dietician		
Sleep Disorder Clinic		
Ambulance Services - Ground	and the second	
(for Emergency Medical Transportation	80% - 20%1	80% - 20%
Only)		0070 - 2070
Ambulance Services – Air (for		
Emergency Medical Transportation		
Only)	$80\% - 20\%^{1}$	80% - 20%1
Non-emergency requires prior		
authorization ²		L

	Coinsur	ance
	Network Non-	
	Providers	Network Providers
Ambulatory Surgical Center and	80% - 20%1	60% - 40%
Outpatient Surgical Facility	8076 - 2076	0076 - 4076
Birth Control Devices - Insertion and	1000/ 00/	
Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	60% - 40%
Cardiac Rehabilitation (limited to 36		60% -
visits per Plan Year)	80% - 20%1.2	40%1.2
Chemotherapy/Radiation Therapy		
(Authorization not required when	80% - 20%1.2	60% - 40% ^{1,2}
performed in Physician's office)		1315,3715
Diabetes Treatment	80% - 20%1	60% - 40%
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20%1	Not Covered
Dialysis	80% - 20%1	60% - 40%
Durable Medical Equipment (DME),	0070 2070	
Prosthetic Appliances and Orthotic	80% - 20%1.2	60% - 40% ^{1.2}
Devices		,
Emergency Room (Facility Charge)	80% - 20%1	80% - 20%
Emergency Medical Services	80% - 20%1	80% - 20%
(Non-Facility Charge)	Eyeglass	
Eyeglass Frames and One Pair of	Frames –	
Eyeglass Lenses or One Pair of Contact	Limited to a	No
Lenses (purchased within six months	Maximum	Coverage
following cataract surgery)	Benefit of	100%
Flu Shots and H1N1 vaccines	\$501	
(administered at Network Providers,		0.0000000000000000000000000000000000000
Non-Network Providers, Pharmacy, Job	100% - 0%	100% - 0%
Site or Health Fair)		
Hearing Aids (Hearing Aids are not	80% - 20%1.3	Not
covered for individuals age eighteen (18) and older)		Covered
Hearing Impaired Interpreter Expense	100% - 0%	100% - 0%
High-Tech Imaging – Outpatient	10070 070	10070 070
CT Scans		60% -
• MRA/MRI	80% - 20%1.2	40%1.2
 Nuclear Cardiology PET Scans 		1070
Home Health Care (limit of 60 Visits		60% -
per Plan Year)	80% - 20%1.2	40%1,2
Hospice Care (limit of 180 Days per	80% - 20%1.2	60% -
Plan Year)	3070 - 2070	40%1.2
Injections Received in a Physician's Office (when no other health service is	80% - 20%1	60% - 40%
received)		
Inpatient Hospital Admission (all	80% - 20%1.2	60% -
Inpatient Hospital services included)	80% - 20%	40%1.2
Inpatient and Outpatient Professional	80% - 20%1	60% - 40%
Services Mastactomy Bras (limited to three (3)	transmission property file	
Mastectomy Bras (limited to three (3) per Plan Year)	80% - 20%1	60% - 40%
Mental Health/Substance Abuse –		C001
Inpatient Treatment and Intensive	80% - 20%1.2	60% - 40% ^{1.2}
Outpatient Programs		4070
Mental Health/Substance Abuse – Office	909/ 209/1	(00/ 100/
Visits and Outpatient Treatment (Other than Intensive Outpatient Programs)	80% - 20%1	60% - 40%
Newborn – Sick, Services excluding		
Facility	80% - 20%1	60% - 40%
Newborn – Sick, Facility	80% - 20%1.2	60% -
- Terroria Steat, Facility	0070 2070	40%1.2
Oral Surgery	80% - 20%1.2	60% - 40% ^{1,2}
Pregnancy Care - Physician Services	80% - 20%1	60% - 40%
Preventive Care - Services include		
screening to detect illness or health risks		
during a Physician office visit. The		
Covered Services are based on prevailing medical standards and may	100% - 0%3	100% - 0%
vary according to age and family history.		
(For a complete list of benefits, refer to		
the Preventive and Wellness/Routine		

	Coinsurance	
	Network Providers	Non- Network Providers
Care Article in the Benefit Plan.)		
Rehabilitation Services - Outpatient: • Speech • Physical/Occupational (Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders.)	80% - 20%	60% - 40%
Skilled Nursing Facility (<i>limit 90 Days</i> per Plan Year)	80% - 20%1.2	60% - 40% ^{1.2}
Sonograms and Ultrasounds - Outpatient	80% - 20%1	60% - 40%1
Urgent Care Center	80% - 20%1	60% - 40%
Vision Care (Non-Routine) Exam	80% - 20%1	60% - 40%1
X-Ray and Laboratory Services (low-tech imaging)	80% - 20%1	60% - 40%
¹ Subject to Plan Year Deductible, if applic ² Pre-Authorization Required, if applicable primary. ³ Age and/or Time Restrictions Apply		or Medicare

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:361 (February 2015), effective March 1, 2015, amended LR 43:

Chapter 5. PPO/Consumer-Driven Health Plan Structure—Pelican HRA 1000 Plan

§505. Schedule of Benefits

A. Benefits and Coinsurance

	Coins	Coinsurance	
	Network Providers	Non- Network Providers	
Physician's Office Visits including			
surgery performed in an office setting:			
General Practice	80% -	60% -	
 Family Practice 	20%	40%1	
 Internal Medicine 	2070	4070	
•OB/GYN			
Pediatrics			
Allied Health/Other Office Visits:			
 Chiropractors 			
 Federally Funded Qualified Rural 	80% -	60% -	
Health Clinics	20%	40%	
 Retail Health Clinics 	2076	4076	
 Nurse Practitioners 			
 Physician's Assistants 			
Specialist Office Visits including surgery			
performed in an office setting:			
 Physician 		l	
 Podiatrist 	80% -	60% -	
 Optometrist 	20%	40%	
 Midwife 	2070	4076	
 Audiologist 			
 Registered Dietician 			
Sleep Disorder Clinic			
Ambulance Services - Ground			
(for Emergency Medical Transportation			
Only)	80% -	80% -	
	20%1	20%1	
Ambulance Services – Air	80% -	80% -	
(for Emergency Medical Transportation	20%1	20%	
only)			

	Coinsurance	
	Network Providers	Non- Network Providers
Non-emergency requires prior authorization ²		
Ambulatory Surgical Center and	80% -	60% -
Outpatient Surgical Facility	20%1	40%1
Birth Control Devices - Insertion and	100% -	60% -
Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	0%	40%1
Cardiac Rehabilitation	80% -	60% -
(limited to 36 visits per Plan Year)	20%1.2	40%1.2
Chemotherapy/Radiation Therapy	80% -	60% -
(Authorization not required when performed in Physician's office)	20%1.2	40%1.2
Diabetes Treatment	80% -	60% -
	20%1	40%1
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20%¹	Not Covered
Dialysis	80% -	60% -
	20%1	40%1
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic	80% -	60% -
Devices	20%1.2	40%1.2
Emergency Room (Facility Charge)	80% -	80% -
Emergency Medical Services	20%¹ 80% -	20%¹ 80% -
(Non-Facility Charge)	20%1	20%1
(Eyeglass	
Eyeglass Frames and One Pair of	Frames –	
Eyeglass Lenses or One Pair of Contact	Limited to	No
Lenses (purchased within six months following cataract surgery)	Maximum	Coverage
John Wing Calaract surgery)	Benefit of	
Flu Shots and H1N1 vaccines	\$501	
(administered at Network Providers, Non-	100% -	100% -
Network Providers, Pharmacy, Job Site or	0%	0%
Health Fair) Hearing Aids (Hearing Aids are not	MAY (1970)	
covered for individuals age eighteen (18)	80% - 20% ^{1,3}	Not
and older)		Covered
Hearing Impaired Interpreter Expense High-Tech Imaging - Outpatient	100%-0%	100%-0%
CT Scans	12/22/1	
 MRA/MRI 	80% - 20% ^{1.2}	60% - 40% ^{1,2}
Nuclear Cardiology	2070	4076
PET Scans Home Health Care (limit of 60 Visits)	80% -	60% -
per Plan Year)	20%1.2	40%1.2
Hospice Care (limit of 180 Days per	80% -	60% -
Plan Year) Injections Received in a Physician's	20% ^{1,2} 80% -	40% ^{1.2} 60% -
Office (when no other health service is	20%	40%1
received)		
Inpatient Hospital Admission (all Inpatient	80% -	60% -
Hospital services included) Inpatient and Outpatient Professional	20% ^{1,2} 80% -	40% ^{1.2} 60% -
Services	20%1	40%1
Mastectomy Bras (limited to three (3) per	80% -	60% -
Plan Year) Mental Health/Substance Abuse -	20%1	40%1
Inpatient Treatment and Intensive	80% - 20% ^{1.2}	60% - 40% ^{1.2}
Outpatient Programs	ZU70***	4070***
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other	80% -	60% -
than Intensive Outpatient Programs)	20%1	40%1
Newborn - Sick, Services excluding	80% -	60% -
Facility	20%1	40%1
Newborn - Sick, Facility	80% - 20% ^{1.2}	60% - 40% ^{1.2}
Oral Surgery	80% -	60% -
Oran Surgery	20%1.2	40%1.2
Pregnancy Care - Physician Services	80% - 20%¹	60% - 40%¹
Preventive Care - Services include	100% -	100% -

etwork roviders 0% ³ 80% - 20% ¹	Non- Network Providers 0% ³
80% -	60% -
80% -	60% -
20% ^{1,2}	40% ^{1,2}
80% -	60% -
20%¹	40%¹
80% -	60% -
20%¹	40%¹
80% -	60% -
20%¹	40%¹
80% -	60% -
20%¹	40%¹
	20% ¹ 80% - 20% ¹ 80% - 20% ¹ 80% -

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:364 (February 2015), effective March 1, 2015, amended LR 43:

§507. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays	
Tier 1- Generic	50% up to \$30	
Tier 2- Preferred	50% up to \$55	
Tier 3- Non-preferred	65% up to \$80	
Tier 4- Specialty	50% up to \$80	
90 day supplies for maintenance	Two and a half times the cost of	
drugs from mail order OR at	your applicable co-payment	
participating 90-day retail	A	
network pharmacies		
Co-Payment after the Out Of	f Pocket Amount of \$1,500 Is Met	
Tier 1- Generic	\$0	
Tier 2- Preferred	\$20	
Tier 3- Non-preferred	\$40	
Tier 4- Specialty	\$40	
Prescription drug benefits-31 day refill		
Maintenance drugs: not subject to deductible; subject to applicable copayments above.		
Plan pays balance of eligible expenses		
Diabetic supplies are not subject to a copayment if enrolled in the In- Health/Disease Management Program.		
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket maximum		

Medications available over-the-counter in the same prescribed strength

are	not	covered	under	the	pharmacy	plan.

Smoking Cessation Medications:

Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.

This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription.

Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.

В. ..

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:365 (February 2015), effective March 1, 2015.

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:341 (February 2015), effective March 1, 2015, amended LR 43:

Public Hearing

In accordance with La. R.S. 49:968(H)(2), the Office of Group Benefits will facilitate a public hearing on these proposed substantive changes on August 30, 2017, at 10 a.m. in the Louisiana Purchase Room, located on the first floor of the Claiborne Building, located at 1201 N. Third Street, Baton Rouge LA 70802.

Tommy Teague Chief Executive Office